



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ORTHOPAEDIC SPECIALISTS OF AUSTIN

Respondent Name

CITY OF AUSTIN

MFDR Tracking Number

M4-17-3648-01

Carrier's Austin Representative

Box Number 43

MFDR Date Received

August 14, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our final denial was due to timeliness. We have submitted reconsiderations to York to no avail. I have attached a log of our efforts to collect these services provided... Please forward to your processing department for resolution."

Amount in Dispute: \$900.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On November 17, 2016, that York Risk Services Group, is disputing entitlement of medical and/or indemnity benefits for any diagnosis other than what has been deemed as related to compensable to the above referenced date of injury based on Michael Snow, DC... The provider resubmit corrected claim with different DX code billed past the 95th day timely filing deadline which was denied."

Response Submitted by: CareWorks

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
November 28, 2016 and December 14, 2016	99205 and 99080-73 x 2	\$990.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of claims by health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical bill.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment reason codes:
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment reason codes:
 - 219 – Based on extent of injury
 - 29 –The time limit for filing has expired

Issue

1. What is the timely filing deadline applicable to the medical bills for date of service November 28, 2016?
2. Does date of service December 14, 2016 contain unresolved extent of injury issues?

Findings

1. The requestor seeks reimbursement for CPT Codes 99205 and 99080-73 rendered on November 28, 2016. The insurance carrier denied the disputed service with denial reduction code "29 –The time limit for filing has expired." 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not-later than 95 days after the date the disputed services were provided.

Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

Review of the submitted information finds insufficient documentation to support that a medical bill for date of service November 28, 2016 was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill for the disputed services.

2. The requestor seeks reimbursement for CPT Code 99080-73 rendered on December 14, 2016. The insurance carrier denied the disputed service with denial reduction code "219 – Based on extent of injury." 28 Texas Administrative Code §133.305(b) states that if a dispute regarding extent of injury exists for the same service for which there is a medical fee dispute, the dispute regarding extent of injury shall be resolved prior to the submission of a medical fee dispute.

Documentation provided by the parties supports that the insurance carrier denied payment to the requestor due to an unresolved extent of injury issue. The carrier's explanation of benefits was timely presented to the requestor in the manner required by 28 Texas Administrative Code §133.240.

The Division finds that date of service December 14, 2016 contains an unresolved extent of injury issue. For that reason, this matter is not eligible for adjudication of a medical fee under 28 Texas Administrative Code §133.307.

The Division hereby notifies the requestor that the appropriate process to resolve the extent of injury issue is found a Texas Labor Code, Chapter 410, and corresponding 28 Texas Administrative Code §141.1. The requestor may choose to file the required DWC Form-045 titled *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference (BRC)* to resolve this matter.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	October 13, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** along with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812